DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	15 U	5/29	5113	FORM	: 04/23/2013 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		445075	B. WING		·	04/	08/2013
KINDRE		ABILITATION-MADISON		TREET ADDRESS. 0 431 LARKIN SPE MADISON, TN		, 04,	00)2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFU TAG	(EACH C	IDER'S PLAN OF CORRE ORRECTIVE ACTION SH FERENCED TO THE API DEFICIENCY)	IQULD BE	COMPLETION DATE
K 066 SS=≅			K 01	Room 3 imm posted on 4/ manager. B administrate on all rooms "no smoking for each of t all licensed importance signs on any checks will weeks, then then once po periodically, the QA/IDT	mediately had a no sm (8/2013 by plant oper; eginning 5/6/2013 the or or designee will per s with oxygen in use to g" signage is appropria hose rooms. On 5/6 a staff will be educated and necessity of poster room with oxygen in occur 5 times per week 3 times per week for or week for four week The audits will be p team monthly each re ling with the May201.	noking sign ations e rform checks to ensure that istely posted and 5/7/2013, on the ed no smoking a use. These ek for four four weeks, s and then resented to nonth for 90	May 10, 2013

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

entrance door of resident room #3 revealed there was no 'NO SMOKING' sign posted in the area.

On 4/8/13 at 9:17 AM, observation at the

Administrator

(XB) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
. 4		445075	B. WING			04/08/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 066 K 067 SS=E	This finding was ac Administrator and v Director during the NFPA 101 LIFE SA	knowledged by the verified by the Maintenance exit interview. FETY CODE STANDARD	к 0 к 0	066	K 067 NFPA 101 Life Safety Code Stan 7 1. Exhaust fan in bathroom #3 re		May 10, 2013
į	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2				and operational. 2. Exhaust fan in north hall nur station replaced and operation. 3. Exhaust ducting through roo correct to the out flow duct. The facility plant operations many check every exhaust fan in the facility		
	Based on testing a determined the facil	s not met as evidenced by: nd observations, it was lity failed to maintain the and the air-conditioning			monthly beginning in May 2013 to en exhaust fans are functional and operat. Any fans found to be not operating wi replaced immediately upon discovery, audits and replacements will be discus the QA/IDT team monthly.	ional. Il be These	
	The findings include	ļ				·	
	1. On 4/8/13 at 9:15 #3 exhaust fan reve	SAM, testing of the bathroom ealed the fan was not working.					
	2. On 4/8/13 at 10:0 fan in the North Hall exhaust fan was no	00 AM, testing of the exhaust I Nurses station revealed the t working.					
		O AM, observation within the aled the exhaust fan was air-return duct.					
K 147	Administrator and ve Director during the s	e acknowledged by the erified by the Maintenance survey exit on 4/8/13. FETY CODE STANDARD	K 1	47			
f		1		ŧ		i	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		445075	B. WING		04/	/08/2013	
1		IABILITATION-MADISON	1 .	REET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	COMPLETION DATE		
	This STANDARD is Based on observatifacility failed to main The findings include 1. On 4/8/13 at 11:0 East Hall Nurses stampbile bookshelf block 2. On 4/8/13 at 12:0 attic area above We junction box without These findings were	d equipment is in accordance onal Electrical Code, 9.1.2 anot met as evidenced by: ions, it was determined the stain the electrical equipment. 5 AM, observation within the ation revealed there was a pocking the electric panel #1. 1 PM, observation within the st hall revealed an electric a cover plate. acknowledged by the prifled by the Maintenance	K 147	K 147 Electrical wiring and equipme accordance with NFPA 70. National Code 9.1.2 1. The electrical panel was im unblocked by plant operation manager on 4/8/2013. As on signage has been appropriate to restrict blocking the electrical panels in the facility. All states also be educated on not blocked beginning 5/5/201 completed by 5/10/2013. 2. The electrical junction box cover plate added to it. These repairs will be rewith the QA/IDT team at the 2013 meeting.	mediately ins f 5/5/2013 cly placed rical aff will cking ill be 3 and has had a		
[